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Addiction as an Attachment Disorder: Implications for Group Therapy

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ABSTRACT

This article presents a perspective on addiction that not only substantiates why group therapy is the treatment of choice for addiction, but also integrates diverse perspectives from 12-step abstinence-based models, self psychology, and attachment theory into a complementary integrative formula. Attachment theory, self psychology, and affect regulation theory characterize addiction as an attachment disorder induced by a person's misguided attempt at self-repair because of deficits in psychic structure. Vulnerability of the self is the consequence of developmental failures and early environmental deprivation leading to ineffective attachment styles. Substance abuse, as a reparative attempt, only exacerbates that condition because of physical dependence and further deterioration of existing physiological and psychological structures. Prolonged stress on existing structures leads to exaggerated difficulty in the regulation of affect, which leads to inadequate modulation of appropriate behavior and self-care and increased character pathology.

Addiction treatment has been intricately associated with group therapy for more than 60 years. Ever since alcoholism was first recognized as a diagnostic entity, its treatment has been provided in groups. Starting with Alcoholics Anonymous' (AA) establishment of the 12-step group movement in the 1930s, addiction treatment has shared a synchronicity and compatibility with group therapy. The two have been drawn to each other because of a very simple principle: Substance abusers usually respond favorably to group treatment and are more likely to stay sober and committed to abstinence when treatment is provided in groups. Any treatment modality that facilitates detachment from chemicals and attachment to abstinence will enhance treatment success. Remaining attached to therapy underlies a singularly influential principle of addiction

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treatment: the longer the treatment, the better the prognosis (Leshner, 1997; Project Match Research Group, 1997).

ADDICTION AS AN ATTACHMENT DISORDER

Addiction treatment specialists familiar with attachment theory (Bowlby, 1979) and self psychology (Kohut, 1976) recognize an inverse relationship between addiction and healthy interpersonal attachment. Certain individuals, because of intrapsychic or developmental deficiencies related to genetic and biological substrates, are vulnerable to environmental influences (i.e., substance abuse), which further compromise an already fragile capacity for attachment. Because of the potent emotional euphoric "rush" that alcohol and drugs produce, they are powerfully reinforcing and inhibiting of the more subtle emotional persuasions in a person's life. Consequently, the vulnerable individual's attachment to chemicals serves both as an obstacle to and as a substitute for interpersonal relationships.

It is difficult, if not impossible, for a practicing alcoholic or addict successfully to negotiate the demands of healthy interpersonal relationships. AA members frequently remind each other, "We don't have relationships, we take hostages." Their relationships typically are exploitative, maladaptive, or sado-masochistic. The use of substances initially serves a compensatory function, providing temporary relief by helping lubricate an otherwise cumbersome inadequacy and ineptness in their interpersonal attachment styles. Prolonged substance abuse, because of its toxicity, gradually compromises neurophysiological functioning and erodes existing structure (Parsons & Farr, 1981). Consequently, any interpersonal skills addicts possessed early in their substance abusing careers deteriorate even further. Managing relationships becomes increasingly difficult, leading to a heightened reliance on substances, which accelerates deterioration and addictive response patterns.

CONTRIBUTIONS OF ATTACHMENT THEORY

Attachment theory, like self psychology, can be considered an offspring of object relations theory. While these three theories share important similarities, they hold different allegiances to classical drive theory. The most decisive factor that differentiates attachment theory from the other two theories is the degree to which it differs from classical drive theory on the importance of attachment. Attachment theory holds firmly to the po-

sition that the pains, joys, and meaning of attachment cannot be reduced to a secondary drive. Attachment is recognized as a primary motivational force with its own dynamics, and these dynamics have far-reaching and complex consequences (Bowlby, 1973).

Bowlby recognized that natural selection favored mechanisms that promoted parent-offspring proximity in an environment of evolutionary adaptation. Attachment is not just psychologically driven but is propelled by powerful biological needs for interpersonal closeness. A primary biological function is to secure assistance for survival; this is true for all social mammals and applies to parent-offspring relationships in other species, not just human beings.

The theory also contends that infants and their parents are biologically hard-wired to forge close emotional bonds with each other. These attachments serve important emotional regulatory functions. Animal studies have demonstrated that secure attachment can produce alterations in biochemistry and neurophysiology (Lewis, Amini, & Lannon, 2000). All compatible social mammals regulate each other's physiology and modify the internal structure of each other's nervous and endocrine systems through the synchronous exchange of emotions. This interactive regulatory relationship is the basis for attachment.

Bowlby believed, like Fairbairn (1952), that the primary motivational force in all social mammals is object seeking. However, the way the word *object* was used in psychoanalytic literature troubled Bowlby. The word object had been applied to connote a wide range of concepts, leading to inaccuracies and divergent interpretations. As Marrone (1998) pointed out, the word object had different meanings, acting as either a "thing" or the "target" of a drive or intent. Bowlby preferred the term *attachment figure*, because he felt both that it better captured the bi-personal nature of attachment relationships and that attachment, like Kohut's selfobject transferences, can in itself be reparative.

Bowlby also formulated an alternative model of internalization because he believed the way psychoanalysis defined the process implied something of a mechanical nature, which consisted of making internal what had been external. Bowlby's internal working model (IWM) (Bowlby's 1973) is a representative model of internalization highly compatible with Piaget's theory (1954) of representation and shares some similarities to object relation's description of internalized self and object representations. However, IWM is more theoretically compatible with intersubjectivity theory (Stolorow, Brandchaft, & Atwood, 1987) because

it places more emphasis on how the interpersonal field is created by both individuals within a relationship.

The emotional availability of a caregiver is the crucial factor in determining the makeup of IWM. As Kohut suggested, how the parent "is with" the child is more important than what the parent does. Stern (1995) holds a similar view, because he believes it is the nature of the relationship—the experience of being with—that is internalized and not just the object or self-representation. Marrone (1998) noted that Bowlby defined internalization as "something that has been neither entirely outside nor entirely inside ... what is represented in the person's mind is the relationship and not the parent as a separate entity" (p. 44). IWM contains the position that the primary unit of existence is not the self and object representation but the relationship and the rules that govern that relationship. On the basis of repeated experiences, the infant learns what to expect from the parent. The rules governing these expectations are internalized along with mental representations and guide a person's thoughts, feelings, and behavior in subsequent close relationships. The implied rules of "how I have to be in order to stay in relation with you" define the structure of IWM and become the determining forces that fuel the repetitive nature of their relationships.

ADDICTION AND SELF PSYCHOLOGY

Self psychology provides the most comprehensive theoretical explanation for the relationship between deficits in self structure and addiction. Khantzian's (1982) self-medication hypothesis, which lays the foundation for affect-regulation theory is an extension of Kohut's basic premise (1977) that substance abuse is a compensatory driven behavior (i.e., self deficit theory) resulting from inadequate development of psychic structure.

Psychic structure, from a self psychology perspective, is not an entity or an agent but a capacity, or a class of psychological functions, pertaining to the ability to integrate and organize fragmenting affect into meaningful experience. Structure formation—the acquisition of patterns and meaning—is developed out of the internalization of functions previously provided by external objects and reflects the ability to take over these functions without relying excessively on selfobjects. The deficits in psychic or self-structure that require external augmentation are usually the result of developmental failures related to unmet age-appropriate attach-

ment needs. Conversely, the successful formation and establishment of self-structure is a developmental outcome reflecting the capacity for affect regulation.

Kohut (1977) postulated that all addictions share a singularly underlying similarity: They are all misguided attempts at affect-regulation and self-repair generated by inadequate psychic structure. Until psychic structure is built, addicts will have difficulty establishing intimate attachments and be inclined to substitute a vast array of obsessive compulsive behaviors (e.g., sex, food, drugs, alcohol, work, gambling, and computer games) that serve as distractions from the gnawing emptiness that threatens to overtake them. Consequently, when one obsessive-compulsive behavior is given up, another is likely to be substituted unless the deficiency in self-structure is corrected.

Within the matrix of environmental responsiveness and emotional attunement, the specific process of psychological structure formation develops. Structure is built as the consequence of minor, nontraumatic failures in the responses of empathic selfobjects. Specifically, structure is built when the ruptured bonds between the self and the person providing selfobject functions are restored (Harwood, 1998). Resolving disagreements in an ideal atmosphere of optimal frustration permits the self to gradually internalize the functions previously provided by the selfobject.

In treatment, optimal frustration should not be confused with deliberate attempts on the therapist's part to frustrate the patient. Frustration naturally occurs in any genuine ongoing relationship. "Optimal" refers to the climate established in the holding environment that most favorably allows for the re-establishment of ruptured bonds in an atmosphere of optimal responsiveness. If a proper treatment environment is created, structure formation will be the natural by-product of the spontaneous interactions that occur within the therapy group.

The more the holding environment provides opportunities for ruptured bonds to be repaired, the stronger the structure formation (Beebe, 1993). Kohut called this process transmuting internalization. If affect-regulation and self-soothing are internalized, the person will be less dependent on external sources for gratification. As attachment theory reminds us, however, regardless of our age or emotional development, we always require emotional regulation from others. The denial of the need for others is what leads individuals to seek gratification (e.g., drugs, alcohol, food, sex, work, and gambling) outside the realm of interpersonal relationships.

IMPLICATIONS FOR TREATMENT

The integration of attachment theory and self psychology has a number of important implications for addiction treatment. To utilize the contributions of these two theories, it is important to summarize their positions.

1. Attachment is a fundamental primary motivation in its own right.
2. Actual "real world" happenings matter more than unconscious fantasies or internal drives.
3. The degree to which people can regulate their own emotions is determined by the length and strength of their earliest attachment experiences.
4. Separation and individuation, free from attachment needs, are not legitimate goals for normal development or therapy.
5. The need for attachment and selfobject responsiveness is a lifelong process, not just phase specific.
6. Attachment of child to parent is different than attachment of parent to child. When parents (or therapists) use children (or patients) to meet their own unmet attachment needs, psychopathology results.
7. Caregiving and affiliative relationships (mutuality) are separate developmental stages that are reached when the self is fully developed.
8. Attachment theory holds the position that just as a biochemical intervention (medication) will alter behavior, so too will environmental interventions (removal of stress inducing stimuli, providing secure attachment, etc.) produce alterations in an individual's neurobiological structure and function.

Attachment theory applied to addiction and group therapy has important implications in this age and culture wherein people strive for independence, autonomy, and self-sufficiency but all too often at the cost of alienation from self and others. Alcoholics and addicts, in particular, are notoriously counterdependent individuals, living their lives at the extreme ends of the attachment-individuation continuum. Autonomy is purchased at the price of alienation and the absence of mutuality in their relationships. As Diamond (1996) points out, group therapy not only represents a movement away from one-person psychology but also contains a fundamental interpersonal conception of human beings as always being situated in relations with others. Group therapy, like attachment theory, is based on the implied notion that the essence of being human is social, not individual.

Walant (1995), examining substance abuse from the perspective of attachment theory, views addiction as a secondary substitute that individuals have adapted as a means to cope with the traumatic effects of early, un-

met developmental needs. Walant criticizes our society's overemphasis on separation and individuation that has contributed to the erroneous belief that we can regulate our own emotions. Parental instinct has been sacrificed for cultural norms that have made dependency pathological and needing shameful. To counter the effects of what Walant calls "normative abuse," she recommends a shift in our approach with these patients to one that is more relational and intimate. This allows patients to become part of something greater, larger, and more satisfying than their isolated existences. Through moments of "immersion," the group develops into a secure base—a transformational object—that enables patients to shift their objects of attachment from substances to the group and its members.

ADDICTION TREATMENT AS A TIME DEPENDENT PROCESS

Addiction specialists have long advocated the need for differentiating early treatment strategies from later stage treatment requirements (Flores, 1982; Wallace, 1978). This distinction represents one of the important paradoxes of successful addiction treatment. Clinical interventions that are often successful and necessary in early treatment will prove ineffective if applied unmodified in later-stage treatment, and they can contribute to a relapse rather than enhance continual abstinence.

What differentiates early treatment goals from later-stage treatment requirements is the stance taken toward abstinence. Alcoholism treatment is basically a very simple two step enterprise involving strategic shifts related to abstinence. Early in treatment, the task is to get the alcoholic to stop use of substances. Later in treatment, the alcoholic must be prevented from starting again. Closely related to the "keep it simple stupid" (KISS) approach of AA is the need to adopt strategies that match the special circumstances of the newly abstinent alcoholic and addict.

Abstinence and relapse are governed consequently by two closely related factors. An alcoholic will never seriously consider giving up alcohol until the discomfort experienced becomes greater than the pleasure derived from its use. Conversely, the possibility of successful long-term recovery is greatly reduced unless the alcoholic's new found life of abstinence is more rewarding than the previous one centered around alcohol use. This reflects an important principle of recovery: The alcoholic will not remain abstinent unless more pleasure is derived from a chemically free life than from using alcohol. Since attachment theory holds the posi-

tion that addiction is a compensatory driven compulsion resulting from a the lack of satisfactory attachment experiences, long-term recovery is not possible until the capacity to achieve satisfaction from interpersonal attachments is achieved.

Wallace (1978) was one of the first to write about alcoholism treatment as a time dependent process, reminding us that what an alcoholic needed during the early stages of treatment was far different than what was needed later in treatment. Currently, most addiction treatment specialists hold that treatment strategies be adapted to fit at least three distinct phases of treatment: (1) achieving sobriety, (2) early recovery or abstinence, and (3) advanced or late-stage recovery. Washton (1992), in a similar fashion, suggested substance abusers be moved through differential sequential groups that focus on issues relevant to their particular stages of recovery: (1) early recovery; (2) relapse prevention or maintenance; and (3) long-term recovery. Applying these recommendations to attachment theory, three primary stages of treatment need to be followed in group.

1. Abstinence and detachment from the object of addiction are required before the individual can make an attachment to group or establish an effective therapeutic alliance.
2. Early in treatment, gratification, support, containment, and cohesion are given priority because these strategies maximally enhance attachment possibilities in the group.
3. Once abstinence and attachment to the recovery process are established, deficits in self and character pathology must be modified. An essential part of this stage of treatment requires the patient to develop the capacity for conflict resolution in a non-destructive manner while becoming familiar with mature mutuality and the intricacies that define healthy interdependence and intimacy.

EARLY TREATMENT ISSUES

Most approaches to early-stage addiction treatment take the position that the primary emphasis must be on abstinence, relapse prevention, and managing the cravings stirred up by conditioned responses to external cues (Brown, 1985; Brown & Yalom, 1977; Flores, 1997; Kemker, Kibel, & Mahler 1993; Khantzian, Halliday, & McAuliffe, 1990; Matano & Yalom, 1991). These approaches recognize the fragility of the addict's early recovery, and adaptations in group technique that take these vulnerabilities into careful consideration are strongly recommended. Care-

ful consideration is also given to helping alcoholics or addicts accept their diagnoses and enter into the culture of recovery (Kemker, Kibel, & Mahler, 1993).

The disease concept and abstinence-based treatment strategies that dominate the addiction treatment field often seem at odds with many psychodynamic approaches to group therapy. Most substance abusers cannot tolerate the frustration and regression that is induced by the more classically influenced psychodynamic group approaches as outlined by Bion (1961), Ezriel (1973) and Rice (1963). Addicts and alcoholics, especially those in the early stages of their recovery, respond more favorably to a directive, practical, no-nonsense approach than they do to a therapeutic stance that allows the usual group process dynamics gradually to develop. Substance abusers typically do not tolerate passivity or the absence of gratification very well. If group therapy is to reach its full potential with this population, it requires active leadership.

Activity Level of the Leader

The beginning phase of early group therapy needs to be structured, supportive, and directive, and the group leader must gear most efforts toward keeping the group members attached and emotionally involved with each other. Group therapy works best when it is a vitalizing experience. Substance abusers usually respond more favorably to the group leader who is spontaneous, "alive," and engaging than they do to the group leader who adopts the more reserved stance of technical neutrality associated with the more classic approaches to group therapy. The more passive group leader is likely to be experienced by the substance abuser as withholding, timid, dull, or dead. This stirs up unconscious fears of annihilation and nothingness, which are associated with primitive identifications. Transference distortions are thus heightened, which in turn increases resistance.

However, the increased activity requirements of the group leader do not suggest that he or she be overly charismatic because this can induce fears of engulfment, destructive idealization, competitive distractions, and archaic mergers. Also, this does not imply that the group leader should gratify the group members in an infantile manner. Not only is this unrealistic, anti-therapeutic, and ultimately impossible, but it also feeds the substance abuser's infantile narcissistic grandiosity and demands for immediate gratification. Establishing a climate of optimal frustration

provides the delicate balance needed in meeting the patients' dependency needs until they are able to internalize control over their own destructive impulses and emotions.

Much of the group leader's efforts early in treatment will be directed toward helping group members facilitate affect regulation by labeling and mirroring feelings when they occur in group. The novice group leader will soon learn that substance abusers have difficulty identifying their feelings; they are also notoriously inadequate in communicating them to others. The larger lesson the substance abuser has to learn is that emotions are not only vital to self-understanding but also crucial to the understanding of others' feelings and the negotiation of all forms of intimacy in interpersonal relationships. Paparo and Nebbiosi (1998) summed up these sentiments perfectly when they wrote, "we could define the entire course of a small analytic group as a successful training in empathy of its individual members" (p.71).

Creating the Capacity for Attachment

There is a very subtle interplay between attachment, cohesion, and interaction. Attachment theorists have long recognized an important paradox about attachment: Secure attachment liberates (Holmes, 1996). This is as true for the securely attached child as it is for the securely attached group member. Just as the securely attached child will move greater distances away from his or her caretaker, taking more risks exploring his or her surrounding environment, the securely attached group member will take more risks in group, exploring his or her inner world more readily.

As long as the alcoholic remains attached to alcohol, a therapeutic alliance will not be established. Sometimes creating the capacity for attachment requires nothing more than taking advantage of a well-known fact about attachment: An individual's attachment system opens up during a crisis. Substance abuse and urgent circumstances usually go hand-in-hand. If the group leader is patient and does nothing to interfere with this process, the consequences of a substance abuser's drinking and drug use eventually will provide a favorable therapeutic opportunity. AA refers to this as "hitting bottom."

Clinical Example

For most of his adult life, Bob had consumed alcohol regularly without much difficulty. However, soon after his fortieth birthday, Bob's drinking escalated and he

began to experience blackouts and job related difficulties. His family became more alarmed and encouraged him to seek help. He reluctantly saw three different therapists during this time, terminating therapy each time after a few sessions. Eventually, he lost his job and his wife threatened divorce. Bob reluctantly agreed "to try therapy," but quickly gave up on the sessions complaining, "I'm not like them, I can't stand their self-pity." Following a severe drunken binge that left him devastated and defeated, Bob readily agreed to seek treatment. During the initial interview and his first group session, Bob showed a dramatic shift in his willingness to "let others help me with my problem." He told the group "I have to swallow my pride, admit I am like you, and stop acting like I don't need anyone." Over the next six weeks, he proceeded to become very attached to the group and after treatment stayed active in aftercare and AA.

Providing structure and gratification will help facilitate an emotional attachment to the group. Attachment theorists recognize that both one-to-one and group or network attachments are necessary because originally they serve a biological function to ensure survival. During early development, attachment helped secure assistance for the infant. However, as the individual grows older, affiliative relationships with peers and groups became more important because they involve greater reciprocity and a semantic order (Litchtenberg, Lachmann, & Fosshage, 1992). Affiliative relationships are not based purely on physical proximity but are mediated by a complex set of meanings and representations. If long-term recovery is to be achieved, the capacity to establish affiliative relationships is crucial. One reason AA works as well as it does is because it provides alcoholics the opportunities to substitute affiliative relationships for their addictions.

Support, Cohesion, and Gratification

Giving support and gratification is often dismissed as irrelevant, if not antithetical, to in-depth psychotherapy. Often the notion of support or optimal gratification has been treated pejoratively and the patient's requests for this have been interpreted as resistance. Because these terms have been so misunderstood, Marrone (1998) suggests it may be better to use the term *empathy* when speaking of the substance abuser's need for support or gratification. Research with early attachment experiences supported his suggestion when it was discovered that securely attached children evoke respect and have empathy for children in distress. The capacity to have concern and empathy for others without over-identifying with them is closely related to attachment security.

Following Pines's (1998) suggestions, good-enough selfobject bonds or attachments need to be created with the group so the group itself becomes a selfobject. Group cohesion and attachment are essentially intertwined and necessary if the group is to provide the support and gratification required during early recovery. As Arensberg (1998) wrote, for a group to work, a good-enough and safe-enough environment and group composition must exist.

MIDDLE-STAGE TREATMENT ISSUES

During the later stages of early recovery, helping the addict and alcoholic with affect regulation becomes important for another reason. Relapses are always of primary concern during this stage of treatment and are often related to difficulties with affect regulation. Substance abusers are usually unable to use their feelings as signals and guides in managing or protecting themselves against the instability and chaos of their internal worlds. This disturbance in the regulation of affect is manifested as "an inability to identify and verbalize feelings, an intolerance or incapacity for anxiety and depression, an inability to modulate feelings ... and extreme manifestations of affect, such as hypomania, phobic-anxious states, panic and lability" (Khantzian, 1982, p. 590). A return to using substances only leads to further deterioration in the existing capacity for self-regulation.

The road to recovery requires a careful balance between affect release and affect containment. Since rapid switches in affect-states potentially can be destructive, the substance abuser's feelings must be delicately managed until enough sobriety and emotional stability is achieved to tolerate a closer look at oneself. The potential for a relapse is heightened anytime the substance abuser feels too good or too bad too quickly. Feeling too good too quickly is often a signal that the old narcissistic defenses have returned and the substance abuser will soon be thinking, "I got this thing licked. I'm special. I'm different." On the other hand, feeling too bad too quickly leads to thinking "I don't give a damn. I might as well be using; this is no fun," indicating that abstinence has become intolerable and substance use is the only refuge from the intense discomfort that dominates recovery.

LATE-STAGE TREATMENT CONCERNS

Once the group leader has used the power and the leverage of the group to help the substance abuser internalize responsibility for abstinence from alcohol and drugs, the leader must help the patient come to terms with the internal deficits that contribute to substance abuse. This is not usually possible until the substance abuser has had enough time and distance from the use of substances to allow cognitive processes to stabilize and emotional lability to be contained. Armed with the increased capacity for insight that prolonged abstinence produces, group members will have a better opportunity to discover the destructive interplay between their ineffective attachment styles and substance abuse.

The inability to establish long-lasting gratifying relationships is directly related to the quality of early attachment experiences (Main, 1996). Attachment-oriented group therapy can be defined as a way of eliciting, exploring, integrating, and modifying attachment styles represented within a person's internal working model. Object relations theory has taught us that introjected self and object representations carry within them intense affect and that these internalized introjects contribute to a person's propensity to project their internal experience on to the external world (Ogden, 1982). Through the power of projective identification, we can coerce, induce, and provoke others in our external world to fit our internal expectations. This self-fulfilling prophecy, paradoxically, gives a perverse sense of comfort from the familiarity of the experience, which serves to satisfy the need or drive for consistency, thus reducing anxiety temporarily.

Eventually the substance abuser must come to terms with his/her character pathology and the inability to establish and maintain healthy intimate relationships. The group leader must remain aware of the dysfunctional care-eliciting strategies that the substance abuser has developed early in life and assimilated into the abuser's character structure. This becomes an important focus in the later stages of treatment because the inability to establish healthy relationships is a major contributing factor to relapses and the return to substance use. As Khantzian, Halliday, and McAuliffe (1990) wrote,

> While it is the drug taking that initially brings the person to treatment, it is the treatment of character that leads not only to giving up drugs but also to profound change in one's experience of self and the world...Ultimately we view the treatment of character disorder as the royal road to recovery from addiction. (p. 3)

In a mature group, one in which the members have had the opportunity to achieve some degree of sobriety and abstinence, a strategy that focuses on the present exchanges between group members is more likely to be beneficial. Because increased abstinence will free members from their preoccupation with withdrawal and craving, they can tolerate a less gratifying and more demanding approach. The ultimate aim of group at this stage is to help its members develop the capacity for interpersonal intimacy within the group so that the skills associated with this capacity can be generalized and applied outside the group in the real world.

Because addiction is both a consequence of and solution to the absence of satisfying relationships, the emphasis on the ability to make connections with others becomes crucial during this stage of treatment. Maturity in development implies the ability to perceive self and other as separate, with needs and wishes different from one's own. The capacity to establish empathic, reciprocal relationships based not on demands but on mutuality is a critical developmental task many substance abusers have not mastered. Group members must learn that mature relationships cannot be determined unilaterally by one person but must be achieved through an interactive process of mutual agreement and consent. Crucial themes like dominance and submission and dependency and autonomy will have to be painfully worked through and negotiated in the group.

Compliance or rebellion and acquiescence or domination are usually the only options available in a substance abuser's limited repertoire of responses. If long term sobriety and abstinence is to be maintained, group members must learn how to resolve conflicts rather than abandoning others or allowing their relationships to degenerate into sado-masochistic patterns.

TRANSFERENCE, SHAME, AND OBJECT-HUNGER

The exploration of the destructive forces that prevent the development of mature mutuality can only take place in what Wolf (1988) refers to as the empathic selfobject ambience. Because the activation of shame related to object hunger, dependency, and hostility associated with the transference relationship often is too intense for the alcoholic and addict

to tolerate in individual therapy, group therapy is required. By virtue of the number of group members, group dilutes the intensity of feelings that would otherwise inundate the patient in a one-to-one setting. Thus, addicts can spread their attachments to both several individuals within the group and the group itself, dealing with the shame, hostility, and ambivalence in their relationships without too much fear of retaliation. The response of the group leader, by firm, yet nonhostile, ability to absorb anger, can lay the foundation for later identification. Consequently, the substance abuser's fear of closeness, rejection, attack, and dependency is not as severely threatened. The group provides an alternative to the substance abuser's lifestyle on the streets or in the bars and can serve as a transitional object or holding environment until a more stable sense of self is internalized. The group helps create a safe space between the addict and the group leader. Through identification, a more stable set of internal self and object representations (internal working model) will be incorporated.

Because the group expands transference possibilities, it provides important advantages for long-term recovery. As the group continues to meet and relationships develop, affiliative seeking behavior will be activated. This permits more opportunity for the elicitation and exploration of internal working models, providing group members with a more favorable atmosphere for modifying and altering the repetitive nature of their destructive ways of relating. Once the group becomes an attachment object, it offers a larger number of potential selfobject candidates, creating more diverse transferences and greater possibilities for members to establish the particular extended selfobject functions they require (Harwood, 1986). The opportunities for adversarial and efficacy experiences (Wolf, 1980) are increased, which are basic for the emergence of a separate sense of self (Stolorow, Brandchaft, & Atwood, 1987).

Clinical Example

Betty was an attractive energetic woman in her early thirties with one year of abstinence when she entered a long-term, outpatient therapy group. The group quickly found her to be an exciting, involved group member who was very responsive to others in the group. However, they gradually discovered her propensity to treat them as disparagingly as she treated others outside the group. She would make hasty intense attachments, then quickly become disillusioned or bored with her new relationships. Betty repeated this pattern within the group. She was seductive with the men and dismissive of the women. The only girl in a family with four brothers and a dominant father, she had a love-hate relationship with men while seeing women as unimportant and inconsequential. Her attach-

ment to the group and to one of the group leaders was strong enough to permit her to tolerate the different selfobject responses she evoked in others. Two men engaged her around her typical seductive patterns, while another man remained consistently confrontational of her manipulations. A fourth male member stayed consistently protective and supportive of her, even during her most provocative moments in the group. Two women engaged her competitively, while a third remained empathic and understanding of her difficulties with men. Another woman, Alice, became a new identified object for her. Even though Alice's demeanor was totally opposite of Betty's, Alice was consistently able to get the male members in group to respond to her in a supportive, respectful, and nurturing way because she was gentle and unobtrusive. Betty learned that all quiet women didn't have to be masochistic like her mother. Through the course of her involvement with members of the group, Betty was able to evoke the selfobject responses she required to transform and alter the destructive relational patterns established in her family.

Mutuality and Dependence

The long-term goal of group is mutuality and attachment, which help break the substance abuser's cycle of alienation and isolation. However, as important as attachment is, the maintenance of a sense of separateness is equally so. The polarity between attachment and autonomy has to be carefully managed. Secure attachment can only be established once insecure and ambivalent attachment styles are relinquished (Ainsworth, 1989). If late-stage treatment requirements are successfully achieved, the substance abuser will began to understand and experience healthy mutuality. Each member can learn the important task of resolving conflicts without resorting to alcohol or drugs.

During this final stage of treatment, the group becomes a transformational object—a source for continual interactive relationships that provide the environmental backdrop onto which the old self can be transformed into a new self. Old self and new self are concepts put forth by Shane, Shane, and Gales (1997) and refer to relational configurations that represent internalized representational models that influence old constricting patterns of relating. A new sense of self must be established if the substance abuser's typical cycle of ineffective attachment, conflict, alienation, and isolation is to be altered. The substance abuser's sense of self must not remain tied to the old self in relation to the old other, but rather must be transformed, through the attachment experience, to reflect a new and different way of being in relationship with another.

The self evolves and consolidates in development through the dimensions of intimacy made available through attachment. Creating the capacity for attachment by reaching the alienated self is crucial because it

reactivates the developmental course toward self and self-with-other consolidation that trauma has disrupted. Once the self has been activated through an attachment relationship, the emergence, evolution, and consolidation of a new self can be completed—if the environmental responses remain consistently nurturing and reparative. Gradually, the old self-consolidation, established out of necessity through self-protective strategies, can be relinquished as the old relational configuration is exchanged for a new one.

CONCLUSION

Viewing addiction as an attachment disorder with a problematic need for selfobject responsiveness has important implications for treatment. If addicts and alcoholics are successfully to give up misguided attempts at self-repair, they must learn how to develop mutually gratifying relationships in which needs for selfobject responsiveness are satisfied in a mature way. Since relationships can also be addicting, the addict and alcoholic must learn how to maintain healthy relationships within the group before they can establish them outside of the group. The goal of addiction treatment is similar to the goal of analysis for individuals suffering form narcissistic disturbances. As Kohut (1984) wrote, cure in therapy is obtained when a person can establish healthy relationships outside of the therapeutic milieu.

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